TITLE 8. Industrial Relations

Division 1. Department of Industrial Relations

Chapter 4.5. Division of Workers' Compensation

Subchapter 1. Administrative Director--Administrative Rules

ARTICLE 3.5 Medical Provider Network

Section 9767.1 Medical Provider Networks – Definitions:

(a) As used in this article:

(1) "Ancillary services" means any provision of medical services or goods as allowed in Labor Code section 4600 by a non-physician.

(2) "Covered employee" means an employee whose employer or employer's insurer has established a Medical Provider Network for the provision of medical treatment to injured employees unless:

(A) the injured employee has properly designated a personal physician pursuant to Labor Code section 4600(d) by notice to the employer prior to the date of injury, or;

(B) the injured employee's employment with the employer is covered by an agreement providing medical treatment for the injured employee and the agreement is validly established under Labor Code section 3201.5, 3201.7 and/or 3201.81.

(3) "Division" means the Division of Workers' Compensation.

(4) "Economic profiling" means any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

(5) "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(6) "Employer" means a self-insured employer, joint powers authority, or the state.

(7) "Group Disability Insurance Policy" means an entity designated pursuant to Labor Code section 4616.7(c).

(8) "Health Care Organization" means an entity designated pursuant to Labor Code section 4616.7(a).

(9) “Health Care Service Plan” means an entity designated pursuant to Labor Code section 4616.7(b).

(10) “Insurer” means an insurer or group of insurers under common ownership admitted to transact workers’ compensation insurance in the state of California, or the State Compensation Insurance Fund.

(11) “Medical Provider Network” (“MPN”) means any entity or group of providers approved as a Medical Provider Network by the Administrative Director pursuant to Labor Code sections 4616 to 4616.7 and this article.

(12) “Medical Provider Network Plan” means an employer’s or insurer’s detailed description for a medical provider network contained in an application submitted to the Administrative Director by a MPN applicant.

(13) “MPN Applicant” means an insurer or employer as defined in subdivisions (6) and (10) of this section.

(14) “Nonoccupational Medicine” means the diagnosis or treatment of any injury or disease not arising out of and in the course of employment.

(15) “Occupational Medicine” means the diagnosis or treatment of any injury or disease arising out of and in the course of employment.

(16) “Physician primarily engaged in treatment of nonoccupational injuries” means a provider who spends more than 50 percent of his/her practice time providing non-occupational medical services.

(17) “Primary care physician” means a physician within a medical provider network designated by the MPN applicant to treat injured employees.

(18) “Primary treating physician” means a primary treating physician within the MPN applicant’s medical provider network and as defined by section 9785(a)(1).

(19) “Provider” means a physician as described in Labor Code section 3209.3 or other provider as described in Labor Code section 3209.5.

(20) “Residence” means the covered employee’s primary residence.

(21) “Second Opinion” means an opinion rendered by a medical provider network physician after an in person examination to address an employee’s dispute over either the diagnosis or the treatment prescribed by the treating physician.

(22) “Taft-Hartley health and welfare fund” means an entity designated pursuant to Labor Code section 4616.7(d).

(23) “Third Opinion” means an opinion rendered by a medical provider network physician after an in person examination to address an employee’s dispute over either the

diagnosis or the treatment prescribed by either the treating physician or physician rendering the second opinion.

(24) "Treating physician" means any physician within the MPN applicant's medical provider network other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.

(25) "Workplace" means the geographic location where the covered employee is regularly employed.

Authority: Sections 133 and 4616(g), Labor Code.

Reference: Sections 3208, 3209.3, 3209.5, 3702, 4616, 4616.1, 4616.3, 4616.5 and 4616.7, Labor Code.

Section 9767.2 Review of Medical Provider Network Application

(a) Within 60 days of the Administrative Director's receipt of a complete application, the Administrative Director shall approve or disapprove an application based on the requirements of Labor Code section 4616 et seq. and this article. An application shall be considered complete if it includes information responsive to each applicable subdivision of section 9767.3. Pursuant to Labor Code section 4616(b), if the Administrative Director has not acted on a plan within 60 days of submittal of a complete plan, it shall be deemed approved.

(b) The Administrative Director shall provide notification(s) to the MPN applicant: (1) setting forth the date the MPN application was received by the Division; and (2) informing the MPN applicant if the MPN application is not complete and the item(s) necessary to complete the application.

(c) The Administrative Director's decision to approve or disapprove an application shall be limited to his/her review of the information provided in the application.

(d) Upon approval of the Medical Provider Network Plan, the MPN applicant shall be assigned a MPN approval number.

Authority: Sections 133 and 4616(g), Labor Code.

Reference: Section 4616, Labor Code.

Section 9767.3 Application for a Medical Provider Network Plan

(a) As long as the application for a medical provider network plan meets the requirements of Labor Code section 4616 et seq. and this article, nothing in this section precludes an employer or insurer from submitting for approval one or more medical provider network plans in its application.

(b) Nothing in this section precludes an insurer and an insured employer from agreeing to submit for approval a medical provider network plan which meets the specific needs of an insured employer considering the experience of the insured employer, the common injuries experienced by the insured employer, the type of occupation and industry in which the insured employer is engaged and the geographic area where the employees are employed.

(c) All MPN applicants shall submit one original and one copy of the Cover Page for Medical Provider Network Application and one original and one copy of the application to the Division.

(d) If the network is not a Health Care Organization, Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund, a Medical Provider Network application shall include all of the following information:

(1) Type of MPN Applicant: Insurer or Employer.

(2) Name of MPN Applicant.

(3) MPN Applicant's Taxpayer Identification Number.

(4) Name of Medical Provider Network, if applicable.

(5) Division Liaison: Provide the name, title, address, e-mail address, and telephone number of the person designated as the liaison for the Division, who is responsible for receiving compliance and informational communications from the Division and for disseminating the same within the MPN.

(6) The application must be verified by an officer or employee of the MPN applicant authorized to sign on behalf of the MPN applicant. The verification shall state: "I, the undersigned officer or employee of the MPN applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this application is true and correct."

(7) Nothing in this section precludes a network, entity, administrator, or other third-party, upon agreement with an MPN applicant, from preparing an MPN application on behalf of an insurer or employer.

(8) Description of Medical Provider Network Plan:

(A) Describe the number of employees expected to be covered by the MPN plan;

(B) Describe the geographic service area or areas to be served;

(C) The name, license number, taxpayer identification number, specialty, and location of each physician as described in Labor Code Section 3209.3, or other providers as described in Labor Code Section 3209.5, who will be providing occupational medicine

services under the plan. If the physicians are also part of a medical group practice, the name and taxpayer identification number of the medical group practice shall also be identified in the application. By submission of the application, the MPN applicant is confirming that a contractual agreement exists either between the MPN and the physicians, providers or medical group practice in the MPN or the MPN applicant and the physicians, providers or medical group practice in the MPN.

(D) The name, license number, taxpayer identification number, specialty or type of service and location of each ancillary service, other than a physician or provider covered under subdivision (d)(8)(C), who will be providing medical services within the medical provider network. By submission of the application, the MPN applicant is confirming that a contractual agreement exists between the MPN and these ancillary services in the MPN or the MPN applicant and these ancillary services in the MPN;

(E) Describe how the MPN complies with the second and third opinion process set forth in section 9767.7;

(F) Describe how the MPN complies with the goal of at least 25% of physicians (not including pediatricians, OB/GYNs, or other specialties not likely to routinely provide care for common injuries and illnesses expected to be encountered in the MPN) primarily engaged in the treatment of nonoccupational injuries;

(G) Describe how the covered employees who are temporarily working outside of the MPN's geographical service area will be provided with medical treatment;

(H) Describe how the MPN arranges for providing ancillary services to its covered employees. Set forth which ancillary services, if any, will be within the MPN. For ancillary services not within the MPN, describe how these services will be made available to the covered employees;

(I) Describe how the MPN complies with the access standards set forth in section 9767.5 for all covered employees;

(J) Describe the employee notification process, and attach a sample of the employee notification material;

(K) Attach a copy of the written continuity of care policy as described in Labor Code section 4616.2;

(L) Attach a copy of the written transfer of care policy that complies with section 9767.9;

(M) Attach any policy or procedure that is used by the MPN applicant to conduct "economic profiling of MPN providers" pursuant to Labor Code section 4616.1 and affirm that a copy of the policy or procedure has been provided to the MPN providers;

(N) Provide an affirmation that the physician compensation is not structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment; and

(O) Describe how the MPN applicant will ensure that no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, will modify, delay, or deny requests for authorization of medical treatment.

(e) If the entity is a Health Care Organization, a Medical Provider Network application shall set forth the following:

(1) Type of MPN Applicant: Insurer or Employer

(2) Name of MPN Applicant

(3) MPN Applicant's Taxpayer Identification Number

(4) Name of Medical Provider Network, if applicable.

(5) Division Liaison: Provide the name, title, address, e-mail address, and telephone number of the person designated as the liaison for the Division, who is responsible for receiving compliance and informational communications from the Division and for disseminating the same within the MPN.

(6) The application must be verified by an officer or employee of the MPN applicant authorized to sign on behalf of the MPN applicant. The verification shall state: "I, the undersigned officer or employee of the MPN applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this application is true and correct."

(7) Nothing in this section precludes a network, entity, administrator, or other third-party, upon agreement with an MPN applicant, from preparing an MPN application on behalf of an insurer or employer.

(8) Describe how the MPN complies with the second and third opinion process set forth in section 9767.7;

(9) Confirm that the application shall set forth that at least 25% of the network physicians are primarily engaged in nonoccupational medicine;

(10) Describe the geographic service area or areas to be served, including the geographic service location for each provider rendering professional services on behalf of the insurer or employer and affirm that this access plan complies with the access standards set forth in section 9767.4;

(11) Describe the employee notification process, and attach a sample of the employee notification material;

(12) Attach a copy of the written continuity of care policy as described in Labor Code section 4616.2;

(13) Attach a copy of the written transfer of care policy that complies with section 9767.9 with regard to the transfer of on-going cases from the HCO to the MPN;

(14) Attach a copy of the policy or procedure that is used by the MPN applicant to conduct "economic profiling of MPN providers" pursuant to Labor Code section 4616.1 and affirm that a copy of the policy or procedure has been provided to the MPN providers; and

(15) Confirm that the number of employees expected to be covered by the MPN plan is within the approved capacity of the HCO.

(f) If the entity is a Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund, in addition to the requirements set forth in subdivision (e) [excluding (e)(9) and (e)(15)], a Medical Provider Network application shall include the following information:

(1) The application shall set forth that the entity has a reasonable number of providers with competency in occupational medicine.

(A) The MPN applicant may show that a physician has competency by confirming that the physician either is Board Certified or was residency trained in that specialty.

(B) If (A) is not applicable, describe any other relevant procedure or process that assures that providers of medical treatment are competent to provide treatment for occupational injuries and illnesses.

(g) If a Health Care Organization, Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund has been approved as a MPN, and the entity does not maintain its certification or licensure or regulated status, then the entity must file a new Medical Provider Network Application pursuant to section 9767.3 (d).

(h) If a Health Care Organization, Health Care Service Plan, Group Disability Insurance Policy, or Taft-Hartley Health and Welfare Fund has been modified from its certification or licensure or regulated status, the application shall comply with subdivision (d).

Authority: Sections 133 and 4616(g), Labor Code.

Reference: Sections 3209.3, 4616, 4616.1, 4616.2, 4616.3, 4616.5, and 4616.7, Labor Code.

Section 9767.4 Cover Page for Medical Provider Network Application

[DWC Form]

Authority: Sections 133 and 4616(g), Labor Code.

Reference: Sections 4616, 4616.5, and 4616.7, Labor Code.

For DWC only: MPN Approval Number	Date Application Received: / /

Cover Page for Medical Provider Network Application

1. Name of MPN Applicant_____

2. Address

_____

_____

3. Tax Identification Number

__ __ -- __ __ __ __ __ __ __

4.Type of MPN Applicant

□ Self-Insured Employer □ Joint Powers Authority □ State

□ Insurer

5. Name of Medical Provider Network(s), if applicable: _____

6. If the medical provider network one is of the following deemed entities, check the appropriate box:

□ Health Care Organization (HCO)
□ Health Care Service Plan
□ Group Disability Insurer
□ Taft-Hartley Health and Welfare Trust Fund

7. Name of entity, administrator or other third-party who prepared MPN Application on behalf of MPN applicant (if applicable): _____

8. Signature of authorized individual: "I, the undersigned officer or employee of the MPN applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and ability, the information included in this application is true and correct."

_____

Name of Authorized Individual Title Phone/Email

_____

Signature of Authorized Individual Date Signed

9. Authorized Liaison to DWC:

_____

Name Title Phone/Email

_____

Address Fax number

Submit one original and one copy of this Cover Page for Medical Provider Network Application and one original and one copy of the Application with the information required by Title 8, California Code of Regulations, section 9767.3 to the following address: MPN Application, P.O. Box 420603, San Francisco, CA 94142.

[DWC Mandatory Form - Section 9767.4]

Section 9767.5 Access Standards

(a) An MPN must have a primary care physician and a hospital for emergency health care services, or if separate from such hospital, a provider of all emergency health care services, within 30 minutes or 15 miles of each covered employee's residence or workplace.

(b) An MPN must have providers of occupational health services and specialists within 60 minutes or 30 miles of a covered employee's residence or workplace.

(c) If an MPN applicant believes that, given the facts and circumstances with regard to a portion of its service area, specifically rural areas including those in which health facilities are located at least 30 miles apart, the accessibility standards set forth in subdivisions (a) and/or (b) are unreasonably restrictive, the MPN applicant may propose alternative standards of accessibility for that portion of its service area. The MPN applicant shall do so by including the proposed alternative standards in writing in its plan approval application or in a notice of MPN plan modification. The alternative standards shall provide that all services shall be available and accessible at reasonable times to all covered employees.

(d) The MPN applicant shall have a written policy for arranging or approving medical care if an employee is temporarily working or traveling for work outside the service area when the need for medical care arises.

(e) The MPN applicant shall have a written policy to allow an injured employee to receive emergency health care services from a medical service or hospital provider who is not a member of the MPN.

(f) For non-emergency services, the MPN applicant shall ensure that an appointment for initial treatment is available within 3 business days of the MPN applicant's receipt of a request for treatment within the MPN.

(g) For non-emergency specialist services to treat common injuries experienced by the covered employees based on the type of occupation or industry in which the employee is engaged, the MPN applicant shall ensure that an appointment is available within 20 business days of the MPN applicant's receipt of a referral to a specialist within the MPN.

Authority: Sections 133 and 4616(g), Labor Code.

Reference: Sections 4616 and 4616.3, Labor Code.

Section 9767.6 Treatment and Change of Physicians Within MPN

(a) When the injured covered employee notifies the employer or insured employer of the injury or files a claim for workers' compensation with the employer or insured employer,

the MPN applicant shall arrange an initial medical evaluation with a MPN physician in compliance with the access standards set forth in section 9767.5.

(b) Within one working day after an employee files a claim form under Labor Code section 5401, the employer or insurer shall authorize the provision of all treatment, consistent with guidelines adopted by the Administrative Director pursuant to Labor Code section 5307.27 or, prior to the adoption of these guidelines, the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), and for all injuries not covered by the ACOEM guidelines or guidelines adopted by the Administrative Director, authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based. The employer or insurer shall authorize the treatment with MPN providers for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is rejected. Until the date the claim is rejected, liability for the claim shall be limited to ten thousand dollars ($10,000).

(c) At the time of referral for initial care, the insurer or employer shall notify the employee of his or her right to be treated by a physician of his or her choice within the MPN after the first visit with the MPN physician and the method by which the list of participating providers may be accessed by the employee.

(d) At any point in time after the initial medical evaluation with a MPN physician, the covered employee may select a physician of his or her choice from within the MPN. Selection by the covered employee of a treating physician and any subsequent physicians shall be based on the physician's specialty or recognized expertise in treating the particular injury or condition in question.

Authority: Sections 133 and 4616(g), Labor Code.

Reference: Sections 4604.5, 4616, 4616.3, 5307.27 and 5401, Labor Code.

Section 9767.7 Second and Third Opinions

(a) If the covered employee disputes either the diagnosis or the treatment prescribed by the treating physician, the employee may obtain a second and third opinion from physicians within the MPN. During this process, the employee is required to continue his or her treatment with the treating physician or a physician of his or her choice pursuant to section 9767.6.

(b) If the covered employee disputes either the diagnosis or the treatment prescribed by the treating physician, it is the employee's responsibility to: (1) inform the MPN applicant or person designated by the MPN applicant that he or she disputes the treating physician's opinion and requests a second opinion; (2) select a physician or specialist from a list of available MPN providers; (3) make an appointment with the second opinion physician within 60 days; and (4) inform the person designated by the MPN applicant of

the appointment date. It is the MPN applicant's responsibility to (1) provide a list of MPN providers and/or specialists to the employee for his/her selection based on the specialty or recognized expertise in treating the particular injury or condition in question; (2) contact the treating physician, provide a copy of the medical records or send the necessary medical records to the second opinion physician prior to the appointment date, and provide a copy of the records to the covered employee upon request; and (3) notify the second opinion physician in writing that he or she has been selected to provide a second opinion and the nature of the dispute with a copy to the employee. If the appointment is not made within 60 days of receipt of the list of the available MPN providers, then the employee shall be deemed to have waived the second opinion process with regard to this disputed diagnosis or treatment of this treating physician.

(c) If, after reviewing the covered employee's medical records, the second opinion physician determines that the employee's injury is outside the scope of his or her practice, the physician shall notify the MPN applicant and employee so the MPN applicant can provide a new list of MPN providers and/or specialists to the employee for his/her selection based on the specialty or recognized expertise in treating the particular injury or condition in question.

(d) If the covered employee disagrees with either the diagnosis or treatment prescribed by the second opinion physician, the injured employee may seek the opinion of a third physician within the MPN. It is the employee's responsibility to: (1) inform the MPN applicant or person designated by the MPN applicant that he or she disputes the treating physician's opinion and requests a third opinion; (2) select a physician or specialist from a list of available MPN providers; and (3) make an appointment with the third opinion physician within 60 days; and (4) inform the person designated by the MPN applicant of the appointment date. It is the MPN applicant's responsibility to (1) provide a list of MPN providers and/or specialists to the employee for his/her selection based on the specialty or recognized expertise in treating the particular injury or condition in question; and (2) contact the treating physician, provide a copy of the medical records or send the necessary medical records to the third opinion physician prior to the appointment date, and provide a copy of the records to the covered employee upon request; and (3) notify the third opinion physician in writing that he or she has been selected to provide a third opinion and the nature of the dispute with a copy to the employee. If the appointment is not made within 60 days of receipt of the list of the available MPN providers, then the employee shall be deemed to have waived the third opinion process with regard to this disputed diagnosis or treatment of this treating physician.

(e) If, after reviewing the covered employee's medical records, the third opinion physician determines that the employee's injury is outside the scope of his or her practice, the physician shall notify the MPN applicant and employee so the MPN applicant can provide a new list of MPN providers and/or specialists to the employee for his/her selection based on the specialty or recognized expertise in treating the particular injury or condition in question.

(f) The second and third opinion physicians shall each render his or her opinion of the disputed diagnosis or treatment in writing and offer alternative diagnosis or treatment recommendations, if applicable. Any recommended treatment shall be in accordance with Labor Code section 4616(e). The second and third opinion physicians may order diagnostic testing if medically necessary. A copy of the written report shall be served on the employee, the person designated by the MPN applicant, and the treating physician within 20 days of the date of the appointment or receipt of the results of the diagnostic tests, whichever is later.

(g) If the injured covered employee disagrees with the diagnosis or treatment of the third opinion physician, the injured employee may file with the Administrative Director a request for an Independent Medical Review pursuant to section 9768 et seq.

Authority: Sections 133 and 4616(g), Labor Code.

Reference: Sections 4616 (a) and 4616.3, Labor Code.

Section 9767.8 Modification of Medical Provider Network Plan

(a) The MPN applicant shall serve the Administrative Director with a Notice of MPN Plan Modification before any of the following changes occur:

(1) A change of 10% or more in the providers participating in the network.

(2) A material change in the continuity of care policy.

(3) Change in policy or procedure that is used by the MPN applicant to conduct "economic profiling of MPN providers" pursuant to Labor Code section 4616.1.

(4) Change in the name of the MPN.

(5) Change in geographic service area.

(6) Change in how the MPN complies with the access standards.

(b) The MPN applicant shall file a new application for a medical provider network plan pursuant to section 9767.3 for approval for a change to a new MPN.

(c) The MPN applicant shall serve the Administrative Director with a Notice of MPN Plan Modification within 5 business days of a change of the DWC liaison.

(d) The modification must be verified by an officer or employee of the MPN applicant authorized to sign on behalf of the MPN applicant. The verification shall state: "I, the undersigned officer or employee of the MPN applicant, have read and signed this notice and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this notice is true and correct."

(e) Within 60 days of the Administrative Director's receipt of a Notice of MPN Plan Modification, the Administrative Director shall approve or disapprove the plan modification based on information provided in the Notice of MPN Plan Modification. If the Administrative Director has not acted on a plan within 60 days of submittal of a Notice of MPN Plan Modification, it shall be deemed approved. Except for (a)(4) and (c), modifications shall not be made until the Administrative Director has approved the plan or until 60 days have passed, which ever occurs first. If the Administrative Director disapproves of the MPN plan modification, he or she shall serve the MPN applicant with a Notice of Disapproval within 60 days of the submittal of a Notice of MPN Plan Modification.

(f) A MPN applicant denied approval of a MPN plan modification may either:

(1) Submit a new request addressing the deficiencies; or

(2) Request reconsideration by the Administrative Director.

(g) Any MPN applicant may request reconsideration of the denial by submitting with the Division, within 20 days of receipt of the Notice of Disapproval, a written request for reconsideration with a detailed statement of the basis upon which reconsideration is requested.

(1) The Administrative Director, or his or her designee, may hold a hearing, at the Division's headquarters offices or such other location as the Administrative Director may designate.

(2) At the hearing, the MPN applicant shall have the burden of establishing qualification for approval.

(3) A hearing for reconsideration of the denial of the plan change shall be informal pursuant to the provisions of the Government Code sections 11445.10 through 11445.60.

(h) The Administrative Director shall issue a written decision within 20 days of the last day of the hearing.

(i) A MPN applicant may seek further review of the decision by filing an appeal with the Workers' Compensation Appeals Board, and serving a copy on the Administrative Director, within twenty days after receipt of the decision.

(j) The MPN applicant shall use the following Notice of MPN Plan Modification form:

DWC form #9767.8

Dated:_____
STATE OF CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation

NOTICE OF MPN PLAN MODIFICATION

Name of MPN Applicant_____

MPN Applicant's Taxpayer Identification Number_____

Name of MPN (if applicable) _____

Date of initial application approval and MPN approval number_____

Dates of prior plan modifications approvals_____

Address _____

Phone _____ **E-mail** _____

Contact person _____

Name of entity, administrator, insurance holding company, or other third-party who prepared MPN Application on behalf of MPN applicant (if applicable): _____

Signature of authorized individual: "I, the undersigned officer or employee of the MPN applicant, have read and signed this notice and know the contents thereof, and verify that, to the best of my knowledge and ability, the information included in this notice is true and correct."

_____
Name of Authorized Individual Title Phone/Email

_____
Signature of Authorized Individual Date Signed

Please give a short summary of the proposed modifications in the space provided below and place a check mark against the box that reflects the proposed modification. Please explain whether the modification will adversely affect the ability of the MPN to meet the regulatory and statutory MPN requirements.

_____
_____
_____
_____

☐ Change in Service Area: Provide documentation in compliance with section 9767.5.

☐ Change of MPN name: Provide new MPN name.

☐ Change of Division Liaison: Provide the name and contact information.

☐ Change in Network Providers: Provide the name, license number, and location of each physician by specialty type or name of provider, if other than physician. (Change of 10% or more in Providers)

☐ Change in continuity of care policy: Provide a copy of the revised written continuity of care policy.

☐ Change in Economic Profiling: Provide a copy of the revised policy or procedure.

☐ Other (please describe): Attach documentation.

Authority: Sections 133, 4616(g) and 5300(f), Labor Code.

Reference: Sections 4616 and 4616.2, Labor Code; Sections 11445.10 through 11445.60, Government Code.

Section 9767.9 Transfer of Ongoing Care into the MPN

(a) If the injured covered employee's injury or illness does not meet the conditions set forth in (e)(1) through (e)(4), the injured covered employee may be transferred into the MPN for medical treatment.

(b) Referrals made to providers subsequent to the inception of the MPN shall be made to a provider within the MPN.

(c) Nothing in this section shall preclude an insurer or employer from agreeing to provide medical care with providers outside of the MPN.

(d) If an injured covered employee is being treated for an occupational injury or illness by a physician or provider prior to coverage of a medical provider network, and the injured covered employee's physician or provider becomes a provider within the MPN that applies to the injured covered employee, then the MPN applicant shall inform the injured covered employee and his or her physician or provider that his/her treatment is being provided by his/her physician or provider under the provisions of the MPN.

(e) The insurer or employer shall provide for the completion of treatment for injured covered employees who are being treated outside of the MPN for an occupational injury or illness that occurred prior to the coverage of the MPN and whose treating physician is not a provider within the MPN, including injured covered employees who pre-designated a physician and do not fall within the Labor Code section 4600(d), for the following conditions:

(1) An acute condition. For purposes of this subdivision, an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a duration of not more than 30 days. Completion of treatment shall be provided for the duration of the acute condition.

(2) A serious chronic condition. For purposes of this subdivision, a serious chronic condition is a medical condition due to a disease, illness, catastrophic injury, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over 90 days and requires ongoing treatment to maintain remission or prevent deterioration. Completion of treatment shall be provided for a period of time, up to one year, necessary to complete a course of treatment approved by the employer or insurer and to arrange for transfer to another provider within the MPN, as determined by the insurer or employer. The one year period for completion of treatment starts from the date of determination that the employee has a serious chronic condition.

(3) A terminal illness. For purposes of this subdivision, a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of treatment shall be provided for the duration of a terminal illness.

(4) Performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days from the MPN coverage effective date.

(f) Following the MPN applicant's determination of the injured covered employee's medical condition, the insurer or employer shall notify the covered employee of the determination regarding the completion of treatment. The notification shall be sent to the covered employee's residence and a copy of the letter shall be sent to the covered employee's primary treating physician. The notification shall be written in a language understandable to the employee.

(g) If the injured covered employee disputes the medical determination under this section, the injured covered employee shall request a report from the covered employee's primary treating physician that addresses whether the covered employee falls within any of the conditions set forth in subdivisions (e)(1-4).

(h) If the employer or insurer or injured covered employee objects to the medical determination by the treating physician, the dispute regarding the medical determination made by the treating physician concerning the transfer of care shall be resolved pursuant to Labor Code section 4062.

(i) If the treating physician agrees with the MPN applicant's determination that the injured covered employee's medical condition does not meet the conditions set forth in subdivisions (e)(1) through (e)(4), the transfer of care shall go forward during the dispute resolution process.

(j) If the treating physician does not agree with the MPN applicant's determination that the injured covered employee's medical condition does not meet the conditions set forth in subdivisions (e)(1) through (e)(4), the transfer of care shall not go forward until the dispute is resolved.

Authority: Sections 133, 4616(g), and 4062, Labor Code.

Reference: Sections 4616 and 4616.2, Labor Code.

Section 9767.10 Continuity of Care Policy

(a) At the request of a covered employee, an insurer or employer that offers a medical provider network shall complete the treatment by a terminated provider as set forth in Labor Code sections 4616.2(d) and (e).

Authority: Sections 133 and 4616(g), Labor Code.

Reference: Section 4616.2, Labor Code.

Section 9767.11 Economic Profiling Policy

(a) An insurer's or employer's filing of its economic profiling policies and procedures shall include:

(1) An overall description of the profiling methodology, data used to create the profile and risk adjustment;

(2) A description of how economic profiling is used in utilization review;

(3) A description of how economic profiling is used in peer review; and

(4) A description of any incentives and penalties used in the program and in provider retention and termination decisions.

Authority: Sections 133 and 4616(g), Labor Code.

Reference: Section 4616.1, Labor Code.

Section 9767.12 Employee Notification.

(a) An insurer or employer that offers a Medical Provider Network Plan under this article shall notify each covered employee in writing about the use of the Medical Provider Network as required by Labor Code section 4616.3 prior to the implementation of an approved MPN, at the time of hire, or when an existing employee transfers into the MPN, whichever is appropriate to ensure that the employee has received the initial notification. The notification shall also be sent to a covered employee at the time of injury. The notification(s) shall be written in English and Spanish. The initial written notification shall include the following information:

(1) The name of the person designated by the MPN applicant to be the MPN contact for covered employees;

(2) A description of MPN services;

(3) How to review, receive or access the MPN provider directory. Nothing precludes an MPN applicant from initially providing covered employees with a regional list of providers in addition to maintaining and making available its complete provider listing;

(4) How to access initial care and subsequent care;

(5) How to choose a physician within the MPN;

(6) What to do if a covered employee has trouble getting an appointment with a provider within the MPN;

(7) How to change a physician within the MPN;

(8) How to obtain a referral to a specialist;

(9) How to use the second and third opinion process;

(10) How to request and receive an independent medical review;

(11) A description of the standards for transfer of ongoing care into the MPN; and

(12) A copy of the continuity of care policy as required by Labor Code section 4616.2.

(b) At the time of the selection of the physician for a third opinion, the covered employee shall be notified about the Independent Medical Review process. The notification shall be written in English and Spanish.

(c) Covered employees shall be notified 30 days prior to a change of the medical provider network. If the MPN applicant is an insurer, then a copy of the notification shall be served on the insured employer. The notification shall be written in English and Spanish.

Authority: Sections 133 and 4616, Labor Code.

Reference: Sections 4616, 4616.2 and 4616.3, Labor Code.

Section 9767.13 Denial of Approval of Application and Reconsideration

(a) The Administrative Director shall deny approval of a plan if the MPN applicant does not satisfy the requirements of this article and Labor Code section 4616 et seq. and shall state the reasons for disapproval in writing in a Notice of Disapproval, and shall transmit the Notice to the MPN applicant by U.S. Mail.

(b) An MPN applicant denied approval may either:

(1) Submit a new application addressing the deficiencies; or

(2) Request reconsideration by the Administrative Director.

(c) Any MPN applicant may request reconsideration of the denial of approval by serving the Division, within 20 days of receipt of the Notice of Disapproval, a written Request for Reconsideration with a detailed statement explaining the basis upon which reconsideration is requested.

(1) The Administrative Director, or his or her designee, may hold a hearing, at the Division's headquarters offices or such other location as the Administrative Director may designate.

(2) At the hearing, the MPN applicant shall have the burden of establishing qualification for approval.

(3) A hearing for reconsideration of the denial of approval of an application or plan shall be informal pursuant to the provisions of the Government Code sections 11445.10 through 11445.60.

(d) The Administrative Director shall issue a written decision within 20 days of the last day of the hearing.

(e) An MPN applicant may seek further review of the decision by filing an appeal with the Workers' Compensation Appeals Board, and serving a copy on the Administrative Director, within twenty days after receipt of the decision.

Authority: Sections 133, 4616(g) and 5300(f), Labor Code.

Reference: Sections 4616, Labor Code; 11445.10 through 11445.60, Government Code.

Section 9767.14 Suspension or Revocation of Medical Provider Network Plan; Hearing

(a) The Administrative Director may suspend or revoke approval of a MPN Plan if:

(1) Service under the MPN is not being provided according to the terms of the approved MPN plan.

(2) The MPN fails to meet the requirements of Labor Code section 4616 et seq. and this article.

(3) False or misleading information is knowingly or repeatedly submitted by the MPN or a participating provider or the MPN knowingly or repeatedly fails to report information required by this article.

(4) The MPN knowingly continues to use the services of a provider or medical reviewer whose license, registration, or certification has been suspended or revoked or who is otherwise ineligible to provide treatment to an injured worker under California law.

(b) If one of the circumstances in subdivision (a) exists, the Administrative Director shall notify the MPN applicant in writing of the specific deficiencies alleged. The Administrative Director shall allow the MPN applicant an opportunity to correct the deficiency and/or to respond within ten days. If the Administrative Director determines that the deficiencies have not been cured, he or she shall specify the time period in which the suspension or revocation will take effect.

(c) If the MPN applicant requests reconsideration of the denial of the suspension or revocation, the MPN applicant shall submit to the Division, within 20 days of receipt of the Notice of Action, a written notice of the request for reconsideration with a detailed statement of the basis upon which reconsideration is requested.

(1) The Administrative Director, or his or her designee, may hold a hearing, at the Division's headquarters offices or such other location as the Administrative Director may designate.

(2) At the hearing, the MPN applicant shall have the burden of establishing qualification for approval.

(3) A hearing for reconsideration of the denial of the suspension or revocation shall be informal pursuant to the provisions of the Government Code sections 11445.10 through 11445.60.

(d) The Administrative Director shall issue a written decision within 20 days of the last day of the hearing.

(e) An MPN applicant may seek further review of the decision by filing an appeal with the Workers' Compensation Appeals Board, and serving a copy on the Administrative Director, within twenty days after receipt of the decision.

Authority: Sections 133 and 4616(g) and 5300(f), Labor Code.

Reference: Section 4616, Labor Code.